

# ATTACHMENT 10

## Sample Prior Authorization Request Form (PA/RF) for occupational therapy services

DEPARTMENT OF HEALTH AND FAMILY SERVICES  
Division of Health Care Financing  
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN  
HFS 106.03(4), Wis. Admin. Code

### WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

<b>FOR MEDICAID USE — ICN</b>		AT	Prior Authorization Number <b>1234567</b>	
<b>SECTION I — PROVIDER INFORMATION</b>				
1. Name and Address — Billing Provider (Street, City, State, Zip Code)  Therapy Group 1 W. Williams Anytown, WI 55555		2. Telephone Number — Billing Provider  (XXX) XXX-XXXX	3. Processing Type  112	
		4. Billing Provider's Medicaid Provider Number  12345678		
<b>SECTION II — RECIPIENT INFORMATION</b>				
5. Recipient Medicaid ID Number  1234567890	6. Date of Birth — Recipient (MM/DD/YY)  MM/DD/YY	7. Address — Recipient (Street, City, State, Zip Code)  609 Willow Anytown, WI 55555		
8. Name — Recipient (Last, First, Middle Initial)  Recipient, Ima		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F		
<b>SECTION III — DIAGNOSIS / TREATMENT INFORMATION</b>				
10. Diagnosis — Primary Code and Description  436 CVA		11. Start Date — SOI	12. First Date of Treatment — SOI	
13. Diagnosis — Secondary Code and Description  437.0 Cerebral atherosclerosis		14. Requested Start Date		
15. Performing Provider Number  87654321	16. Procedure Code  97110	17. Modifiers 1 2 3 4 GO	18. POS  11	19. Description of Service  Strengthening exercises 15 min x 3/wk x 11 wk
				20. QR  33
				21. Charge  XXX.XX
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.				22. Total Charges  XXX.XX
23. SIGNATURE — Requesting Provider  <i>I.M. Provider</i>				24. Date Signed  MM/DD/YY
<b>FOR MEDICAID USE</b>		Procedure(s) Authorized:		Quantity Authorized:
<input type="checkbox"/> Approved Grant Date _____ Expiration Date _____				
<input type="checkbox"/> Modified — Reason:				
<input type="checkbox"/> Denied — Reason:				
<input type="checkbox"/> Returned — Reason:				
SIGNATURE — Consultant / Analyst _____				Date Signed _____